APPLICATION FOR PERMIT TO ADMINISTER ANESTHESIA AND SEDATION

State Form 46159 (7-93)
Approved by State Board of Accounts, 1993

Health Professions Bureau, Indiana State Board of Dental Examiners
402 West Washington St., Rm. 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

For official use only	
Application fee	
Date fee paid	Date application received
Receipt number	**274 - 12B**

INSTRUCTIONS: *Please type or print. Submit $15.00 application fee, payable to Health Professions Bureau.*

APPLICANT INFORMATION

I am applying for the following permit, *(Please check appropriate box below .)*

☐ General Anesthesia and Deep Sedation
(includes authorization to administer Light Parenteral Conscious Sedation)

☐ Light Parenteral Conscious Sedation *(only)*

Name *(Last, first, middle, (maiden)*

Address *(Number, street, rural route)*

City, state, Zip code

Primary office address *(Number, street, rural route)*

City, state, Zip code

Telephone number	Birthdate *(Month, day, year)*
Social Security number *	* This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1, in order to perform its statutory function.

DENTAL DEGREE (S) GRANTED

Name of school	Dates attended
Location of school	

EDUCATION AND TRAINING

(To be completed by applicants for General Anesthesia - Deep Sedation or Light Parenteral Conscious Sedation Permits)

General Anesthesia - Deep Sedation Permits / Advanced Education Program

Name of school	Dates attended
Location of school	Degree received
Date certification / degree was granted	Program title

Light Parenteral Conscious Sedation Permit / Training and Education

To be completed by applicants if: ***predoctoral training was obtained***

Name of school	Dates attended
Location of school	

To be completed by applicants if: ***postdoctoral training was obtained***

Name of school - hospital	Dates attended	
Location of school - hospital		
Program title	Number of hours of instruction	Number of patients managed

WHERE DO YOU INTEND TO ADMINISTER GENERAL ANESTHESIA, DEEP SEDATION, LIGHT PARENTERAL CONSCIOUS SEDATION	
List all offices - hospitals where you currently intend to administer : *general anesthesia*	
Name of office	Address (Street, city, state, Zip code)
Name of office	Address (Street, city, state, Zip code)
Name of hospital	Address (Street, city, state, Zip code)
Name of hospital	Address (Street, city, state, Zip code)

List all offices - hospitals where you currently intend to administer : *deep sedation*	
Name of office	Address (Street, city, state, Zip code)
Name of office	Address (Street, city, state, Zip code)
Name of hospital	Address (Street, city, state, Zip code)
Name of hospital	Address (Street, city, state, Zip code)

List all offices - hospitals where you currently intend to administer: *light parenteral conscious sedation*	
Name of office	Address (Street, city, state, Zip code)
Name of office	Address (Street, city, state, Zip code)
Name of hospital	Address (Street, city, state, Zip code)
Name of hospital	Address (Street, city, state, Zip code)

List all states in which you have been licensed to practice, including the license number and date of issuance.		
Name of state	License number	Date of issuance
Name of state	License number	Date of issuance
Name of state	License number	Date of issuance
Name of state	License number	Date of issuance

ADVANCED CARDIAC LIFE SUPPORT INFORMATION	
List the date you were most recently certified in advanced cardiac life support or received certification as an instructor in advanced cardiac life support:	Date of issuance
State the name and location of the entity where you received your training in advance cardiac life support	
Name	
Location	

☞ **PLEASE SUBMIT DOCUMENTATION VERIFYING YOUR CERTIFICATION WITH YOUR APPLICATION.**

DISCIPLINARY INFORMATION		
Has disciplinary action ever been taken regarding any dental license you hold or have held ? *(If yes, provide information below and submit a sworn statement giving full details.)*		☐ Yes ☐ No
State	Charge	
Date	Disposition	
Are you now, or have you ever been treated for a drug abuse or alcohol problem ? If yes, submit a sworn statement giving full details.		☐ Yes ☐ No
Have you ever been convicted of, pled guility or nolo contendere to:		
✣ a violation of any federal, state or local law relating to the use, manufacturing, distributing,or dispensing of controlled substances or of drug addiction ?		☐ Yes ☐ No
✣ any offense, misdemeanor, or felony in any state ? *(except for violation of traffic laws resulting in fines.)*		☐ Yes ☐ No
If yes to either offense above submit a sworn statement giving full details. Include the violation, location, date and disposition.		

I hereby swear under penalties of perjury that the above statements are true, complete and correct.	
Signature	Date

AUTHORIZATION FOR RELEASE OF INFORMATION

To whom it may concern:

I hereby authorize, request and direct any person, firm officer, corporation, association, organization or institution to release to the Health Professions Bureau or the Indiana State Board of Dental Examiners any files, documents, records or other information pertaining to the undersigned, requested by said Board, or any of its authorized representatives,in connection with the processing of my application for a permit to administer anesthesia or sedation.

I hereby release the aforementioned persons, firms, officers corporations, associations, organizations and institutions from any and all liability with regard to such inspection or furnishing of any such information.

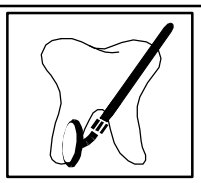
I further authorize the Health Professions Bureau and the Indiana State Board of Dental Examiners to disclose to the aforementioned organizations, persons, institutions any information which is material to my application, and I hereby specifically release said Bureau and Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

VERIFICATION

I hereby swear under penalties of perjury that the above statements are true, complete and correct.	Date
Signature	Print name

Indiana State Board of Dental Examiners
Health Professions Bureau
402 W. Washington Street, Room 041
Indianapolis, Indiana 46204



INSTRUCTIONS FOR FILLING OUT ANY FORMS

Please read these instructions carefully before filling out any forms.

In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or your application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become public record. Your grade transcripts are confidential except in circumstances where their release is required by law, in which case you will be notified.

Your Social Security Number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Prior to administering general anesthesia, deep sedation, or light parenteral conscious sedation, a dentist shall obtain from the board a permit which authorizes the dentist to utilize the form of anesthesia or sedation desired.

A dentist holding a permit to administer general anesthesia and deep sedation will not be required to obtain a separate permit to administer light parenteral conscious sedation.

APPLICANTS FOR A GENERAL ANESTHESIA-DEEP SEDATION PERMIT

(Which includes authorization to use light parenteral conscious sedation)

1. **Complete** the enclosed application for a permit.
2. **Enclose** a check or money order in the amount of $15.00 made payable to the Health Professions Bureau.
3. **Submit** satisfactory evidence of completion of educational and training requirements:
   (a) a certificate of completion of the educational or training program signed by the dean of the board approved dental school or director of the board approved anesthesiology or oral maxillofacial surgery residency from which the training was obtained; or
   (b) an official transcript from the board approved dental school which clearly designates completion of the education or training.
4. (a) The same level of training is necessary for administration of both deep sedation and general anesthesia.
   (b) The residency in anesthesiology or oral and maxillofacial surgery shall meet the following requirements:
   (1) The training program must be full time and be a minimum of one (1) year in duration.
   (2) The program shall be a joint cooperative effort between the training institution's department of anesthesiology and department of dentistry.
   (3) Instruction in both didactic basic science and clinical procedures must be incorporated into the program. This instruction may be given in a seminar or conference format, or may include formal courses.
   (4) The anesthesiology residency or anesthesiology portion of the oral surgery residency shall include preanesthetic patient evaluation, administration of anesthesia in the operating room on a daily scheduled basis, postanesthetic care and management, and emergency call.
   (5) Training must include anesthetic management for ambulatory outpatient procedures and the use of inhalation and intravenous sedation techniques.
   (6) The program shall include instruction in pain and pain mechanisms; and shall include training in and successful completion of a course in advanced cardiac life support.
5. **Submit** an affidavit that the practitioner's office meets the board's equipment requirements. You must submit a separate affidavit for each office where you will administer anesthesia or sedation. *(sample form attached)*
6. **Submit** proof that you are trained in and have successfully completed a course in advanced cardiac life support or that you are certified as an instructor in advanced cardiac life support.
7. **Mail** all required items to the Health Professions Bureau. *(see address above)*

APPLICANTS FOR A LIGHT PARENTERAL CONSCIOUS SEDATION PERMIT ONLY

1. **Complete** the enclosed application for a permit.
2. **Enclose** a check or money order in the amount of $15.00 made payable to the Health Professions Bureau.
3. **Submit** satisfactory evidence of completion of educational and training requirements:
   (a) the applicant graduated from an approved dental school which included training in conscious sedation techniques at the predoctoral level; or
   (b) the applicant completed an intensive postdoctoral training program in the use of light parenteral conscious sedation.
4. **Submit** an affidavit that the practitioner's office meets the board's equipment requirements. You must submit a separate affidavit for each office where you will administer light parenteral conscious sedation.
5. **Submit** proof that you are trained in and have successfully completed a course in advanced cardiac life support or that you are certified as an instructor in advanced cardiac life support.
6. **Mail** all required items to the Health Professions Bureau. *(see address above)*

APPLICANTS FOR A LIGHT PARENTERAL CONSCIOUS SEDATION PERMIT ONLY *(Continued)*

Please read these instructions carefully before filling out any forms.

Satisfactory evidence of completion of educational and training requirements means:

(a) A certificate of completion from the educational or training program signed by the dean of the board approved dental school or medical school, or director of a board approved hospital program from which the training was obtained.

(b) An official transcript from a board approved dental school which clearly designates completion of the education or training.

(c) A certificate of completion from a continuing education program *(postdoctural training program)* which meets the requirements *(as described below).* The certificate of completion shall be signed by the director of the continuing education program.

A predoctoral training program in light parenteral conscious sedation shall meet the following requirements:

(1) Be obtained in a board approved dental school.

(2) Instruction shall include the following areas:

(a) Philosophy of pain control and patient management, including the nature and purpose of pain.

(b) Review of physiologic and psychologic aspects of pain and apprehension.

(c) Physiologic monitoring.

(d) Organic pain problems and their management.

(e) Control of preoperative and operative pain and apprehension.

(f) Techniques of administration of light parenteral conscious sedation including intramuscular, intravenous, submucosal, and subcutaneous sedation.

(g) Prevention, recognition and management of complications and emergencies, including the principles of advanced life support. Instruction shall include training in and successful completion of a course in advanced cardiac life support.

(h) Interaction of pharmacological and psychological methods.

(i) Control of postoperative pain and apprehension.

(3) Each student must have experience in managing a minimum of ten (10) patients.

A postdoctoral training program in light parenteral conscious sedation shall meet the following requirements:

(1) Include a minimum of sixty (60) hours of instruction.

(2) Include management of at least ten (10) patients.

(3) Include the following in the course content:

(a) Historical, philosophical and psychological aspects of pain and anxiety control.

(b) Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.

(c) Definitions and descriptions of physiological and psychological aspects of pain and anxiety.

(d) A description of the stages of drug-induced central nervous system depression through all levels of consciouness and unconsciouness, with special emphasis on the distinction between the conscious and the unconscious state.

(e) Review of respiratory and circulatory physiology and related anatomy.

(f) Pharmacology of agents used in the conscious sedation techniques being taught, including drug interaction and incompatability.

(g) Indications and contraindications for the use of the conscious sedation modality under consideration.

(h) Review of dental procedures possible under conscious sedation.

(i) Patient monitoring, with particular attention to vital signs and reflexes related to consciousness.

(j) Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

(k) Prevention, recognition and management of complications and life-threatening situations that may occur during use of conscious sedation techniques, including the principles of advanced life support. Instruction shall include training in and completion of a course in advanced cardiac life support.

(l) The importance of using local anesthesia in conjunction with conscious sedation techniques.

(m) Venipuncture: anatomy, armanentarium and technique.

(n) Sterile techniques in intravenous therapy.

(o) Prevention, recognition and management of local complications of venipuncture.

(p) Description and rationale for the technique to be employed.

(q) Prevention, recognition and management of systemic complications of intravenous sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

EMERGENCY EQUIPMENT SAMPLE AFFIDAVIT

This type of affidavit must be completed and submitted by all applicants for a permit. **This is a sample.** Please prepare your own affidavit. Your office must contain the listed emergency equipment. If your office contains additional emergency equipment please list it also. You must submit an equipment affidavit for each office location where you will administer *general anesthesia deep sedation or light parenteral conscious sedation.*

Photocopies of this sample will not be accepted by the board.

I, _____ ,

Indiana Dental License Number _____ being duly sworn upon my oath do hereby swear or affirm that

my dental office located at _____
(address,street, city, state)

Contains the following emergency equipment:

(1) A portable oxygen system capable of delivering positive pressure highflow oxygen (i.e., ambu bag, Robert Shaw Demand valve, or equivalent), full face mask and oral and nasal airways.

(2) An emergency source of power which can be utilized in the event of a power failure and is sufficent to operate the equipment and provide an emergency source of light.

(3) A suction apparatus capable of aspirating gastric contents efficiently from the pharynx or mouth.

(4) An electrocardiograph.

(5) A laryngoscope and assorted blades.

(6) Endotracheal tubes in assorted sizes.

(7) Drugs necessary to follow advanced cardiac life support protocols.

(8) Equipment for continuous intravenous fluid infusion to facilitate drug administration.

(9) A stethoscope.

(10) A body temperature measuring device.

(11) A defibrillator.

(12) A pulse oximeter.

FURTHER AFFIANT SAYETH NAUGHT.

Signature

NOTARY CERTIFICATE

STATE OF _____ }
COUNTY OF _____ } SS:

I, _____, having been duly, say that I am the above-named applicant, that I have personally prepared the foregoing affidavit, and that the same is true to the best of my knowledge and belief.

Signature of applicant	Signature of Notary Public	
Printed or typed name of applicant	Printed or typed name of Notary Public	
Date subscribed and sworn to Notary Public	County of residence	Date commission expires

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